TRUSTMARK INSURANCE COMPANY (MUTUAL)
400 Field Drive
Lake Forest, Illinois 60045
(Herein We, Us and Our)

MAJOR MEDICAL POLICY
PPO PLAN A

This is Your Policy of Insurance (Policy) while You are Insured. It is issued in consideration of Your Application and the first Premium payment.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy if Your Application has been accepted and premium has been timely paid. Benefit payment is governed by all the terms, conditions, exclusions and limitations of the Policy.

This Policy was issued on the basis that the information on Your Application was correct and complete. **If any information on the Application was not correct or complete, write to Us within ten (10) days of receipt of this Policy. An error or omission may result in loss of coverage as of its effective date.**

Right to Examine: If You are not satisfied with this Policy, return it to Our home office or to Your agent within ten (10) days after the date You receive it. The Policy will then be canceled and any premium paid will be refunded.

Please Read this Policy Carefully

Donald M. Peterson
President & Chief Executive Officer

Frank G. Gramm
Corporate Secretary & General Counsel

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SCHEDULE OF BENEFITS
PPO PLAN A

Lifetime Maximum	$2,000,000
Calendar Year Deductible The amount you must pay each year for covered services before We have an obligation to pay any amount.	$2,500
Maximum Deductible Per Family	two times ($5,000)
Percentage Covered After Deductible Is Met: The annual maximums after which you no longer have to pay for specific services:	80% of the first $10,000 of eligible charges; 100% thereafter
Non-Preferred Provider Penalty The reduction in the percentage covered for services provided by a non-Preferred Provider	10%
Percentage Covered For Outpatient Treatment of Accidental Injury	80%
Lifetime Maximum For Inpatient Care of Substance Abuse	$10,000; no coverage for outpatient treatment.
Treatment for Inpatient Mental Health Disorders	30 days for inpatient mental health treatment; 60 day maximum per lifetime; no coverage for outpatient treatment.
Hospital Inpatient Care	Includes semi-private room, intensive care and cardiac care services and supplies and other hospital services.
Pre-Admission Certification	Pre-admission certification is required for all Hospital admissions. Emergency or maternity care admissions must be certified within 48 hours. A $500.00 penalty may apply if you are hospitalized and pre-admission certification has not been obtained.
Length of Stay	Unlimited as long as medically necessary.
Chiropractic Treatment	15 visits per Calendar Year
Hospice Care	Benefits are provided for inpatient and outpatient hospice care. There is a $3,000 lifetime maximum.
Home Health Care	120 visits per Calendar Year Care must begin within 14 after discharage from Hospital confinement.
Skilled Nursing Care	30 days per Calendar Year for the same or related Injury or Sickness
Percentage Covered for Outpatient Surgery	80% of the first $10,000 of eligible charges; 100% thereafter
Child Wellness Services	Up through age 5. Includes age appropriate immunizations and laboratory exams. No deductible applies.
Maternity	Covered as any other illness.

PPO - IMPORTANT INFORMATION ON THE USE OF YOUR COVERAGE

Your coverage contains different levels of benefits based upon whether You use Preferred or non-Preferred Providers. We require You to notify Us before You receive certain covered services. The provider may assist You in this process. You will receive a listing of Physicians and/or Hospitals that reflects the Preferred Providers under this plan. Prior to receiving care, You will want to confirm that Your Physician is a Preferred Provider in order to receive the highest level of benefits. The listing of network providers will be updated at least annually.

You receive the highest level of benefits when You use Preferred Providers. Preferred Providers agree to provide health care services at negotiated prices. Preferred Providers have agreed not to bill You more than the negotiated amount. These providers have agreed to file Your claim for You and reimbursement will be made directly to them for covered services You receive. If You use a Preferred Provider, We will pay Your eligible covered expenses, in excess of Your deductible and coinsurance, as shown on the Schedule of Benefits. The coinsurance amount You pay will be lower if You use a Preferred Provider than if You use a non-Preferred Provider.
In order to be eligible for the highest level of benefits offered by this plan, You must use Preferred Providers. The service area where Our Preferred Providers are located is shown in the PPO Provider Directory.

We pay a lower level of benefits when You use non-Preferred Providers. These providers have not signed contracts with Us to provide services at agreed-upon prices. When You choose these providers, We will only pay the usual, customary and reasonable amount of Your eligible covered expenses, as shown on the Schedule of Benefits. You will be responsible for Your deductible, coinsurance and any amount of the billed charges which exceeds the usual, customary and reasonable fees.

If a medically necessary service is not available from a Preferred Provider, Your Preferred Provider may refer You to a non-Preferred Provider and the eligible covered expenses will be considered for payment at the Preferred Provider benefit level. Some individual providers practice in more than one location. On occasion, an individual provider may be a Preferred Provider at one location, but a non-Preferred Provider at another location. Be sure to check Your provider's preferred status at the location where You are seeking care. Services will be reimbursed subject to determination of usual, customary and reasonable charges.

All medical benefits for emergency services, whether using a preferred or non-Preferred Provider, will be the same as for using a Preferred Provider. Emergency services are those medical services provided within 72 hours following an injury or a medical emergency.
Covered expenses shall be considered incurred when the service or treatment is furnished or performed or the supplies are purchased.

We, upon receipt of a notice of claim involving a non-Preferred Provider, will send to the claimant a claim form for filing proof of loss. If such forms are not furnished within 10 working days after giving notice, the claimant shall be deemed to have met the requirements of the policy as to proof of loss upon submitting, within 90 days, written proof covering the nature and extent of the loss for which the claim is made. A Preferred Provider will complete the claims forms and send them to Us.

Subject to any written direction of the insured in the application or otherwise, all or a portion of any medical claim may, at Our option, be paid directly to the organization or person rendering such services, but it is not required that the service be rendered by a particular organization or person. When You use a Preferred Provider, We may make all payments directly to the Preferred Provider.

AMBULATORY CARE FACILITY - Ambulatory Care Facility means a freestanding or Hospital-based facility or physician's office providing preventive diagnosis, emergency therapeutic services, surgery or other treatment not requiring overnight confinement. The facility must be a licensed public or private establishment with an organized medical staff of physicians with permanent facilities. These facilities must provide physician services and registered professional services whenever a patient is in the facility.

APPLICATION - The individual Application is the document showing information about the Insured and his/her dependents concerning benefits and health conditions. The individual Application is part of the Policy.

CALENDAR YEAR - Calendar Year means a period of twelve (12) consecutive months, beginning on January 1 and ending on December 31 of the same year.

CASE MANAGEMENT - Case Management is an interagency, standardized process that focuses on coordinating a number of services needed by a Covered Person. It includes a standardized, objective assessment of an Insured's needs and the development of an individual service or care plan that is based on the needs assessment and is goal oriented.

In instances when a Covered Person is suffering from a complex illness or injury that requires ongoing health care, a specially trained case manager shall be assigned to monitor that care. The case manager shall coordinate services, resources and information with the Insured, family, health care provider and insurer.

COINSURANCE - Coinsurance is that percentage of Your eligible medical expenses or supplies, as shown on the Schedule of Benefits, covered herein that You pay after the Deductible has been satisfied. Your Coinsurance amount is satisfied when You have met Your stop loss maximum for each Calendar Year. The Coinsurance amount does not include that portion of the fees charged in excess amount of the usual, customary and reasonable fees.

COMPLICATIONS OF PREGNANCY - Complications of Pregnancy are covered the same as any other illness. Coverage is for conditions whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy.

CONFINEMENT - Confinement means confinement in a Hospital as a registered inpatient on the advice of the Covered Person's physician.

CONTINUED STAY REVIEW - Continued stay review is a review process by a utilization review committee, after an initial determination has been made, to determine the appropriate length of Hospital stay for a given injury, Sickness or pregnancy.

COVERED PERSON - Covered Person includes the Insured and any Insured dependent as shown on the Schedule Page.

DEDUCTIBLE - The Deductible is the amount of eligible medical expenses that must be incurred before payment of benefits will be made. The Deductible amount is shown on the Schedule of Benefits. If all or any portion of an Insured's or dependent's Deductible for a Calendar Year is applied against covered expenses incurred during the last three months of the Calendar Year, the Insured's or dependent's Deductible for the next ensuing Calendar Year shall be reduced by the amount so applied.

The Deductible must be satisfied each Calendar Year by each Covered Person separately, except as follows:

1. If three persons covered under this Policy satisfy the Calendar Year Deductible, no further Deductibles are required for that Calendar Year.

2. If two or more persons covered under this Policy sustain injuries in a common accident, only one Deductible amount will be applied to all eligible medical expenses arising out of that

accident subject to the following conditions:

a. the Deductible will be waived for the Insured with the largest amount of expenses from that accident.

b. charges will be processed without applying a Deductible only for services related to that accident.

c. the Deductible, if any, will only be waived to the extent it was not previously satisfied during that Calendar Year.

ELECTIVE SURGERY - Elective surgery means any non-emergency surgical procedure that may be scheduled at the patient's convenience without jeopardizing life or causing serious impairment to bodily functions. The procedure will not be considered elective if the operation is of an emergency nature, as determined by the attending physician.

ELIGIBLE INDIVIDUAL - An Eligible Individual must have: 1) creditable health insurance coverage for 18 months or longer; 2) the most recent coverage under a Eligible Dependent that is not fully insured or provides benefits through a group health insurance Policy or contract; 3) exhausted any COBRA (or continuation) coverage; 4) no eligibility for coverage under any other group health insurance plan, Medicare or Medicaid and 5) no break in coverage greater than 62 days.

Certain children may also be deemed Eligible Individuals, even if they do not satisfy the provisions of 1) above (i.e., do not have a full 18 months of creditable coverage). These are children who were covered under any creditable coverage within 31 days of birth, adoption, or placement for adoption and have not had a break in coverage greater than 62 days. An Eligible Dependent child does not include dependents who are eligible for Medicare or Medicaid or who are covered under any other group health insurance.

ELIGIBLE DEPENDENT - In order to be eligible for dependent coverage, the dependent must have been covered under the individual's Eligible Dependent (or continuation thereof) immediately prior to the election of coverage under this plan and satisfy the requirements as outlined under the definition of "Eligible Individual". Dependent means the Insured's spouse, if not legally divorced, or any unmarried child of the Insured, subject to the following conditions and limitations:

1. The term "dependent" shall include any unmarried child who is dependent on the Insured for support and maintenance and who is: (a) 19 years of age or less; or (b) 25 years or less so long as the Policy continues in effect, the child remains a dependent of the Policyholder, and the child, in each Calendar Year since reaching the age of 19 years, has been enrolled for five calendar months or more as a full-time student in a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury.

   The term dependent also includes any child who is: (a) age 19 or older and incapable of self-support due to mental or physical disability, and (b) chiefly dependent on the Insured for support and maintenance. If a claim is denied because the child has attained age 19, the burden is on the Insured to establish that the child is, and has continued to be, disabled. The additional premium required for such child will be at the premium rate applicable to the child's then attained age. In the case of a disabled child, coverage may continue until the child is capable of self-support or until the Policy terminates. We have the right, at any time, to require proof of the incapacity and dependency, but no more than once a year after the first two years.

2. The term "child" as used in this definition shall include any stepchild. Such child must be under the legal guardianship of the Insured or spouse and dependent upon the Insured or spouse for principal support. The term "child" also includes any adopted child. Such adopted child is covered from the date of placement for adoption.

3. If a husband and wife are separately insured for this insurance, their children, if otherwise eligible, shall be considered dependents of either the husband or of the wife, but not of both.

4. An Insured may add an otherwise eligible child for medical coverage upon payment of the premium required for such child for which s/he is required by a court order.

ELIGIBLE MEDICAL EXPENSES - Eligible medical expenses are those actually incurred by a Covered Person as a result of Sickness or injury. Such expenses may not exceed the usual, customary and reasonable charges for services or supplies required by a physician. Such expenses must be medically necessary. An expense is considered to be incurred on the date the service is performed or purchase is made. All eligible expenses must be incurred while this Policy is in force. Except for nonpayment of premium, termination of this Policy shall not prejudice an existing claim.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES - Experimental or investigational services include:

1. Care, procedure, treatment protocol or technology which is:

   a. not widely accepted in the United States as safe, effective and appropriate for the injury or Sickness by the recognized medical organizations as established by the Health Care Financing Administration (HCFA);
   b. used in limited human application, but has not yet received approval by the proper government agency or consensus by the medical profession that the service is effective for the stated condition; or
   c. experimental, in the investigation or clinical study stage, or conducted as part of research protocol.

2. Drugs, tests or technology which are:

   a. not approved for general use by the Federal Food and Drug Administration;
   b. considered experimental, or primarily performed or utilized at a research center;
   c. for investigational use; or
   d. approved for a specific medical condition but applied to another condition.

   A drug or biologic used in an antineoplastic regimen is not excluded on the grounds that such drug has not been approved by the Federal Food and Drug Administration for the particular indication if one of the following conditions exists: 1) the drug is recognized for treatment of the indication by the United States Pharmacopeial Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information; or 2) the drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published either in the United States or Great Britain.

GROUP HEALTH PLAN - An "Eligible Individual" must have his or her most recent coverage under a Group Health Plan. A Group Health Plan is considered an employee welfare benefit plan, to the extent that the plan provides medical care to employees or their dependents directly or through reimbursement, and shall include a governmental plan or a church plan. Governmental plans are for employees of government entities, not public welfare or other benefit plans such as Medicare, Medicaid or Indian Health Service (IHS).

HOME HEALTH CARE - Home health care means a formal program of care and treatment which is performed in the home of patients discharged from a Hospital or skilled nursing facility, which is medically necessary and results in a shortened Hospital or skilled nursing facility confinement, which is not available from members of Your household, and which is organized and administered by and under the direct supervision of a Hospital or Medicare certified or state licensed home health care or certified rehabilitation agency.

HOSPITAL - Hospital means a health institution licensed, planned, organized, operated and maintained to offer facilities, beds and services over a continuous period exceeding 24 hours to individuals requiring diagnosis and treatment for Sickness, injury, deformity, abnormality and pregnancy. Clinical laboratory, diagnostic X-ray and definitive medical treatment under an organized medical staff shall be provided within the institution. Treatment facilities for emergency and surgical

services shall be provided either within the institution or by contractual agreement for those services with another licensed Hospital. Services provided by contractual agreement shall be documented by a well defined plan for the provision of contracted services, related to community needs. Definitive medical treatment may include obstetrics, pediatrics, psychiatry, physical medication and rehabilitation, radiation therapy, and similar specialized treatment.

Hospital does not mean convalescent, nursing, rest or extended care facilities, or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.

IMMEDIATE FAMILY - Immediate family means the Insured, the Insured's spouse, and respective parents, brothers, sisters, children, grandchildren and siblings.

INJURY - Injury means an accidental bodily injury sustained by a Covered Person. All injuries due to the same accident are deemed to be one injury.

INSURED - Insured is the person to which the Policy is issued.

INTENSIVE CARE UNIT - Intensive care unit means a special area apart from other Hospital facilities which provides constant nursing attendance, contains special equipment for treatment of the critically or seriously ill and is under the direction of a physician and/or intensive care committee of the medical staff. This includes a specialized care unit that provides four (4) or more hours nursing care per day.

A special cardiac ward that meets all of the above conditions is considered a special care unit.

MEDICAL EMERGENCY - A medical emergency is a sudden onset of a medical condition (injury or illness) with acute symptoms of severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or injury is of such a nature that failure to obtain immediate medical attention could result in: (a) placing the patient's health in serious jeopardy; (b) causing other serious medical consequences; (c) causing serious impairment to bodily functions; (d) causing serious dysfunction to any body part or organ.

MEDICALLY NECESSARY - Medically necessary means services or supplies when provided by a Hospital, physician or other licensed provider of health care services to diagnose or treat a Sickness or injury that:

1. are consistent with the Covered Person's condition, diagnosis, ailment or injury;
2. are recognized as usual and customary treatment of the given condition and are recognized as accepted standards of practice in the United States;
3. are not primarily for the convenience of the Covered Person, the patient's family, the physician or other provider;
4. are performed in the least costly setting required by the medical condition; and
5. are not experimental, investigational or unproven.

The fact that a physician has prescribed, ordered, recommended, or approved a service or supply does not, of itself, make the service or supply medically necessary. Your physician or other service provider must furnish sufficient documentation to support the recommended treatment and/or services.

MEDICARE - Medicare means any of the benefits of Title XVIII of the Social Security Act of 1965, and all amendments to it.

MENTAL HEALTH DISORDERS/SUBSTANCE ABUSE TREATMENT - Inpatient mental health and substance abuse treatment is covered for inpatient services and is covered to the extent that it is medically necessary. Benefit maximums are shown on the Schedule Page.

NURSE - Nurse means a graduate nurse, including a registered nurse or licensed practical nurse. It does not include a person who ordinarily resides in the same household with the Insured or who is related by blood, marriage or legal adoption to the Insured or his/her spouse.

PHYSICIAN - Physician means, with respect to any medical care and service, a person:

1. certified or licensed under the laws of the state where treatment is rendered, is qualified to perform the particular medical or surgical service for which claim is made and who is practicing within the scope of such certification or licensure;
2. any other health care provider or allied practitioner if, and as, mandated by state law; and
3. not related to the Covered Person.

This term does not include: (a) an intern; or (b) person in training.

POLICY - Policy means this document which describes:

1. The insurance benefits to which a Covered Person is entitled.
2. To whom the benefits are payable.
3. Limitations or requirements that may apply.
4. Who is eligible for coverage under the Policy and when they are eligible.

POLICY YEAR - The first Policy year begins on the effective date of coverage, shown on the Certification Page, and ends 12 months later. Subsequent Policy years begin on the Policy anniversary dates and end 12 months later.

PRECERTIFICATION - Precertification is a screening process to determine whether or not inpatient hospitalization and/or specific equipment or methods of treatment are medically necessary. Precertification is not a guarantee of any benefits.

PREFERRED PROVIDER
A preferred provider is a provider (who is not a member of your immediate family) of health care services or supplies who has agreed to participate in our Preferred Provider Network.

PREFERRED PROVIDER NETWORK
A Preferred Provider Network is a selected network of Physicians, Hospitals and other health care providers who have agreed to deliver health care services at negotiated prices to Trustmark Insurance Company (Mutual). You will receive a listing of the Physicians, Hospitals and other health care providers who are part of this plan. This network directory listing will be updated no less than annually and provided to you following any revisions/updates.

PRESCRIPTION DRUG - Prescription drug means any substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

REASONABLE FEES - Reasonable fees means fees that meet the criteria of usual and customary fees and are justifiable considering the circumstances of the particular case in question.

SICKNESS - Sickness means disease or illness of a Covered Person not otherwise excluded herein. Sickness includes pregnancy and Complications of Pregnancy, as defined, but does not include learning disabilities, attitudinal disorders, attention deficit disorder, or disciplinary problems.

SKILLED NURSING FACILITY - A skilled nursing facility is a licensed facility offering skilled nursing care for patients no longer needing Hospital care. A skilled nursing facility must:

1. Be operated pursuant to law.
2. Be approved for Medicare benefits or be qualified to receive such approval.
3. Be primarily engaged in providing skilled nursing care under the supervision of a licensed physician in addition to room-and-board accommodations.
4. Provide continuous 24-hour-a-day nursing service by or under the supervision of a registered nurse.
5. Maintain a daily record of each patient.

It cannot include:

1. Any home, facility or part thereof used primarily for rest.
2. A home or facility for the aged or for the care of alcoholism, chemical dependency or drug addiction.
3. A home or facility primarily used for the care and treatment of mental diseases or disorders, custodial or educational care.

In the case of two or more periods of extended care confinement, the second and each later confinement must begin within 90 days after discharge of Hospital confinement for which benefits are payable to be considered a continuation of the original confinement.

STOP LOSS MAXIMUM - The stop loss maximum is the maximum amount of eligible expenses that an Insured person must incur after the Deductible has been satisfied before eligible expenses are paid at 100% for the balance of that Calendar Year. The stop loss maximum is shown on the Schedule of Benefits.

USUAL AND CUSTOMARY
Usual means the fees most often charged by the provider for a given service. Customary means the range of usual fees charged by most providers for comparable services or materials within the same area. Area means a county or other region as is necessary for Us to establish a customary rate.

WE, OUR US, ITS - Trustmark Insurance Company (Mutual).

WORKERS' COMPENSATION LAW - Workers' Compensation Law means any Workers' Compensation Act, any occupational disease act, any employer's liability act, or any other similar state or federal legislation or regulation.

YOU, YOUR - Any Covered Person.

RENEWAL PROVISION

This Policy may be renewed at the applicable rate subject to the Maximum Life Benefit Amount.

We may cancel or refuse to renew this Policy as of an anniversary date only for non-payment of premium after the allowed grace period or as otherwise permitted in the "Termination" section and by federal and state law.

We reserve the right to discontinue offering all individual coverages in the state.

If we refuse to renew all policies of this kind in the state in which the Policy was issued [or in Your class], we will notify You in writing 180 days before the date the coverage will expire, at Your last known address in Your file.

We reserve the right to modify premium rates becoming due on this Policy. The increase will apply to all Insureds in the same class. The Insured will be notified in writing at least 60 days prior to the Policy anniversary date of any increase other than one based on attained age. Each term of coverage is determined by the premium payment and begins and ends at 12:01 a.m. where the Insured lives.

EFFECTIVE DATE

INSURED

The effective date of coverage for the Insured is shown on the Schedule Page.

DEPENDENT

The effective date of coverage for Eligible Dependents of the Insured is the date the Insured becomes insured and the Application for coverage is approved.

If a child is born to or adopted by the Insured while coverage is still in force, the newborn child is

covered from the moment of birth, or in the case of adoption, the date of placement for adoption. Such newborn coverage includes coverage for injury or Sickness including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity. Coverage will not include routine nursery care - see the Exclusions and Limitations provision in the Policy.

The newborn or adopted child's coverage will cease after 31 days following the date of birth, unless the Insured is covered under family coverage or elects family coverage by submitting to Us within 31 days after the date of birth, notice of the child's birth or notice of placement for adoption and payment of the required premium (calculated from the monthly due date 31 days following the child's date of birth or placement for adoption).

TERMINATION

TERMINATION OF INSURED'S INSURANCE

An Insured will cease to be covered on the earliest of the following dates:

1. Nonpayment of premium, subject to the grace period.
2. The date this Policy is terminated by the Insured.
3. Termination of the plan where the issuer is ceasing to offer coverage in the individual market in this state.
   We reserve the right to discontinue offering all individual coverages in the state. If this is done, We will provide notice in writing, to You, at least 180 days before the date the coverage will expire.
4. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage as described in state or federal law.

TERMINATION OF DEPENDENT'S INSURANCE

A dependent will cease to be covered on the earliest of the following dates:

1. Nonpayment of premium, subject to the grace period.
2. The date the Insured's insurance terminates.
3. With respect to any dependent's insurance benefit, the date of termination of such benefit.
4. The date the person ceases to qualify as a dependent, at which time they will be eligible for a conversion Policy.
5. Termination of the plan where the issuer is ceasing to offer coverage in the individual market in this state.
   We reserve the right to discontinue offering all individual coverages in the state. If this is done, We will provide notice in writing, to You, at least 180 days before the date the coverage will expire.
6. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage as described in state or federal law.

If we accept a premium after a specified termination date or if such termination date falls within a period for which we accepted premiums, coverage will continue to the end of the premium payment period subject to the misstatement of facts provision.

Termination will be without prejudice to any claim originating prior to the effective date of termination.

BENEFIT PROVISIONS

MAJOR MEDICAL BENEFIT

If a Covered Person incurs major medical expenses, We will pay the usual, customary and reasonable fees for the area where the service is rendered for the following described benefits, subject to the Schedule of Benefits and our right to determine that the service or treatment was

medically necessary. Payment of benefits will begin after the Deductible has been satisfied and will be subject to the Coinsurance percentage. Payment of benefits will be subject to the Maximum Lifetime benefit of $2,000,000 per person as shown on the Schedule of Benefits.

1. **Hospital Room and Board and Intensive Care.**

   a. Charges for regular Hospital room, board and general nursing care for each day of Hospital confinement, up to the average semiprivate room rate. The average semiprivate room rate will be paid for confinement in a private room.
   b. Charges for confinement in an intensive care unit for room, board and all nursing services.

2. **Hospital Miscellaneous Services.** Charges for miscellaneous medical services; operating rooms; and medically required drugs, medicines and materials provided by the Hospital.

3. **Physicians' Fees.** Charges by a physician for diagnosis, medical treatment or surgery.

4. **Outpatient Surgery.** Charges for surgery, services and supplies furnished by an ambulatory care facility as an outpatient or in the outpatient surgical department of a Hospital where charges are incurred for both the operating room and the recovery room. Charges for surgery, pathology, radiology, services and supplies furnished at a physician's office, clinic, or in the Hospital emergency room.

5. **Therapy.** charges for x-ray, radioactive therapy or chemotherapy. Charges for therapy by a licensed physical therapist, speech therapist or inhalation therapist for rehabilitative purposes only.

6. **Prescription Drugs.** Charges for prescription drugs payable as any other Sickness, subject to the Deductible and Coinsurance.

7. **Prescription medication.** A drug has been approved by the Food and Drug Administration (FDA) and which can under federal or state law be dispensed only pursuant to a prescription order.
   Prescription medications peculiar to this benefit do not include the following:
   a. medications used for weight control;
   b. infertility medications or birth control pills and devices;
   c. experimental, investigational or unproven services for drugs;
   d. medications for cosmetic purposes only;
   e. medications for smoking cessation;
   f. medications available over-the-counter (OTC) that do not require a prescription order or refill by federal or state law and any medication that is equivalent to an OTC medication;
   g. medication not approved by the FDA for the condition being treated;
   h. replacement prescription medications resulting from loss or theft; and
   i. medication dispensed while Hospital confined, dental prescriptions and prescription vitamins including prenatal vitamins.

8. **Anesthesia.** Charges for anesthesia and its administration.

9. **Ambulance.** Charges for medically necessary transportation by a professional licensed ground ambulance service or licensed air ambulance service (within the continental U.S.) for the Covered Person to the nearest Hospital qualified to furnish treatment for the condition. Such transportation must be certified as medically necessary by the attending physician.

10. **Home health care.** Subject to the Deductible and Coinsurance, charges made or coordinated by a state licensed or Medicare certified home health care agency or certified rehabilitation agency for any of the following medical services and supplies provided in accordance with a home health care plan which is supplied to Us at Our request.

    a. Part-time or intermittent nursing care and certified nurse aid services under the

supervision of a registered graduate nurse or a qualified therapist.

b. Part-time or intermittent services of a home health aide which consists only of care for the patient, and which are medically necessary as part of the home health care plan (must be under the direction of a registered nurse or medical social worker).

c. Physical, respiratory, occupational speech therapy, audiology or inhalation therapy provided by licensed therapists working under a treatment plan prescribed by a licensed physician and when the patient has periodic medical follow-up by the referring physician.

d. Medical supplies, laboratory services, medical social services, prostheses and orthopedic appliances, rental or purchase of durable medical equipment, drugs, medicine and insulin obtainable only upon the written prescription of a physician.

e. Nutrition counseling provided by or under the direction of a registered dietitian or nutritionist if medically needed as part of the home health care plan.

f. Eligible medical expenses made by the home health care agency are limited to not more than 120 home health care visits during a Calendar Year. For the purpose of determining the benefits payable, each visit by an employee of a home health care agency will be considered one home health care visit and each 4 hours of home health aide services in a 24-hour period will be considered one home health care visit. Eligible medical expenses do not include charges incurred for services or supplies not specified in the home health care plan or charges incurred by or on behalf of an individual other than the individual designated in the home health care plan; charges for the services of any individual who is a member of the Insured's or dependent's family or who ordinarily resides in the Insured's or dependent's home; charges for homemaker services and services to aid in the formal activities of daily living; charges that are payable under Workers' Compensation or employer's liability acts; or charges for any period during which the Insured or dependent is not under the continuing care of a physician. The physician must certify that if home health care were not provided, the injury or Sickness would require confinement in a Hospital or extended care facility.

11. **Hospice benefit.** Benefits will be provided subject to the Deductible and Coinsurance for expenses incurred for the following services provided by a hospice:

a. room and board;
b. medically necessary services and supplies;
c. intermittent and 24-hour on call nursing care, by or under the supervision of a registered graduate nurse;
d. intermittent and 24-hour on-call social/counseling services;
e. bereavement counseling services for the immediate family (spouse, children, parents) within three months following the Covered Person's death;
f. certified nurse aid services or nursing services;
g. therapies including physical, occupational and speech;
h. nutritional counseling by a nutritionist or dietitian;
i. short-term general inpatient (acute) care or continuous home care up to 30 days which may be required during a period of crisis, for pain control or symptom management;
j. medical supplies, drugs and biologicals, prosthesis and orthopedic appliances, oxygen and respiratory supplies, diagnostic testing, rental or purchase of durable medical equipment, transportation and physician services;

Such services must be:

(i) furnished in an inpatient Hospital facility or the Covered Person's home; and
(ii) provided only if the physician certifies that the Covered Person is terminally ill with a life expectancy of 6 months or less except if the Covered Person lives beyond six months, coverage will be provided for an additional 6 months.

Benefits will not be provided for:

(i) services of volunteers or persons who do not regularly charge for their services;
(ii) services of a pastor to a member of his/her congregation; or
(iii) expenses excluded under the Exclusions and Limitations section of this Policy.

12. **Skilled Nursing.** Facility charges for daily room and board and other services and supplies, exclusive of professional services, subject to the following limitations and conditions:

a. The daily benefit shall be limited to 1/2 the average semiprivate Hospital room rate where the patient was confined prior to the skilled nursing facility, but in no event will it exceed the extended care facility's daily rate for a semiprivate accommodation. This benefit shall be payable for a maximum of 30 days of confinement on account of the same related injury or Sickness per Calendar Year.

b. Successive periods of confinement resulting from the same or related causes shall be considered as one continuous period of confinement unless the subsequent period of confinement begins at least 8 days after the date the previous confinement ended.

c. Confinement in an skilled nursing facility must be recommended by a physician for an injury or Sickness which caused the Covered Person to be hospitalized for at least 3 consecutive days, and must begin within 14 days after discharge from such Hospital confinement.

13. **Other services and supplies.** Charges for:

a. Oxygen and rental of equipment for the administration of oxygen (up to the purchase price of the equipment);

b. Blood plasma or whole blood, where not replaced;

c. Artificial limbs, eyes, larynx and other prosthetic devices (except replacement or experimental devices);

d. Casts, splints, trusses, crutches and braces, except dental braces;

e. Diagnostic x-ray examination and laboratory tests;

f. Rental of a standard wheelchair, standard hospital-type bed, iron lung, or similar medical equipment (up to the purchase price of the equipment);

g. Outpatient expenses including physician's services, x-rays and treatment incurred for care in connection with the detection and correction by manual or mechanical means of: dislocation of vertebrae, spine, back or neck; musculoskeletal sprain or strain surrounding vertebrae, spine, back or neck; subluxation of vertebrae; or misplaced vertebrae; are limited to 15 visits per covered person per Calendar Year;

h. Mammogram examinations when ordered by the Insured person's Physician;

i. Diabetic supplies (insulin covered as a prescription drug);

j. Prostate Specific Antigen tests [and the Office Visit associated with this test] when ordered by the Insured Person's Physician;

k. Treatment for newborn or adopted children born or adopted with cleft lip, cleft palate or both including oral and facial surgery, surgical management, follow-up care by plastic surgeons and oral surgeons, prosthetic treatment, obturators, speech appliances, feeding appliances, orthodontic treatment, prosthodontic treatment, rehabilitative speech therapy, otolaryngology treatment and audiological assessments and treatment;

l. Expenses for a pap smear on an annual basis or more frequently if ordered by a Physician; and

m. Treatment for temporomandibular joint dysfunction.

14. **Child Wellness.** Coverage for routine physical exams provided by a Physician for dependent children from birth through age 5 years includes medical history, complete physical examination, developmental assessment, appropriate immunizations, anticipatory guidance for the parents, and laboratory testing in keeping with prevailing medical standards.

15. **Organ and tissue transplant benefit.** The plan will pay eligible covered charges related to services for kidney, bone marrow, cornea, lung, heart, liver or pancreas transplants. All organ and tissue transplants are subject to the precertification requirement. This benefit shall include expenses incurred by the covered person for 30 days prior to the transplant and one year from the date of the organ transplant for follow-up care, including any complications.

Subject to the lifetime maximum benefit shown on the Schedule of Benefits, we will pay for costs involved in the procurement of a donor organ including the Hospital expenses of

the donor.
We will not pay benefits for animal to human transplants, the implantation of artificial or mechanical organs or organ transplants that are as experimental or investigational as defined in the Policy at the time the procedure is performed. For this purpose, We will rely on the findings and assessment of:

(i) The Office of Medical Application of Research of the National Institutes of Health, the Office of Technology Assessment of the United States Congress, or similar authoritative bodies; and
(ii) National Cancer Institute, Health Care Financing Agency, the Data Project of the AMA and the USDA.

PRECERTIFICATION REQUIREMENT
We require that You obtain precertification of the medical necessity for the following medical procedures, goods and services:

1. All non-emergency, medical, surgical inpatient Hospital admissions and maternity stays extending beyond 48 hours for normal delivery and 96 hours for C-sections.
2. All non-emergency outpatient surgeries.
3. Durable medical goods with a cost in excess of $500.00.
4. Hospice or home health care.
5. Organ transplants.
6. High risk maternity care.
7. All rehabilitative therapies including cardiac, speech, physical, occupational therapy and all back and spinal care and treatment.

All requests for non-emergency precertification must be received at least 5 working days before the date of service. You will be responsible for the first $500 of any covered expense or, where applicable, one day's room and board charges for in-Hospital procedures, in addition to any Deductible and Coinsurance amounts each time You fail to precertify. We will provide the Covered Person with the name, address, and toll-free number of the precertification provider. Precertification is a determination of medical necessity and does not guarantee benefits are payable. We may require a second surgical opinion which will be reimbursed at 100%.

EMERGENCY CERTIFICATION

All emergency Hospital admissions must be certified within 48 hours following admission or the next business day or as soon as reasonably possible. This does not include emergency room visits where an admission to the Hospital does not take place. You will be responsible for the first $500 of any covered expense in addition to any Deductible and Coinsurance amounts each time You fail to certify.

PRIOR APPROVAL REQUIREMENT
Prior approval means the approval that You or Your provider are required to obtain from us, prior to the delivery of certain services or supplies listed below.
Prior approval must be requested in writing. We will notify You or Your provider of our decision within 5 business days after we receive the request for prior approval.
In addition to the precertification requirement, covered expenses for the following surgical procedures will not be covered unless an Insured or provider receives written approval from us prior to the performance of the surgery: (1) Blepharoplasty (eyelid); (2) Rhinoplasty (nose); and (3) Abdominoplasty.

PREGNANCY NOTIFICATION REQUIRED

You are required to notify us within 30 days after confirmation of pregnancy to allow identification of potential high risks. Coverage is still subject to the provisions stated herein.

EXCLUSIONS AND LIMITATIONS

The following charges may not be used to satisfy the Deductible amount. In addition, We will not pay for any such charges incurred for:

1. Any service or supply that is not medically necessary.
2. That part of any charge for services or supplies that is in excess of the usual, customary and reasonable charges.
3. Any charge for services or supplies not within the scope of the authorized practice of the provider rendering the service or supplies; services or supplies provided by a practitioner not recognized by this Policy.
4. Outpatient care for alcoholism, chemical dependency or drug addiction.
5. Routine physical exams for individuals over age 5.
6. Outpatient care for mental illness and nervous disorders.
7. Care or treatment of Sickness or injury as a result of or caused by:
   a. War, declared or undeclared.
   b. Participation in a felony, riot, insurrection, or an illegal operation.
   c. Service in the armed forces or auxiliary units, including National Guard or Military Reserve active duty. If coverage ceases due to entry into the armed forces on a full-time basis, any unearned premiums shall be refunded on a prorated basis upon written notification to Us of entry into such service.
8. Charges incurred in connection with injury or Sickness for which a Covered Person is entitled to benefits under any Workers' Compensation or similar law.
9. Cosmetic surgery or plastic surgery. Reconstructive surgery when such service is incidental to trauma, infection or other diseases of the involved part may be payable. Reconstructive surgery because of congenital disease or anomaly of a covered dependent child, born or adopted while covered under this Policy, that has resulted in a functional defect is payable. Submucous resections are excluded unless reasonably necessary to the treatment of injury or Sickness. Reconstructive surgery when necessary to restore a normal bodily function is payable.
10. Any charges for Physician's services or x-ray examinations involving any of the teeth, their surrounding tissue or structure, unless the charges are:
    a. in connection with the treatment or removal of malignant tumors.
    b. for services provided within 90 days of an injury and as a result of injury to sound natural teeth without dental invasion while this Policy is in force.
    c. medical services for TMJ.
11. Eye refractions or the purchase or fitting of eyeglasses, intraocular lenses, contact lenses, lenses for the treatment of aphakia, radial keratotomy, vision therapy, hearing aids or otoplasty.
12. Free services of a federal, veteran's, state or municipal Hospital.
13. Suicide or attempted suicide and intentionally self-inflicting injuries or poisoning
14. Marital counseling, educational, training or behavioral problems including such conditions as: bulimia, anorexia nervosa, other eating disorders and attention deficit disorders.
15. Charges for breast reduction or augmentation or complications arising from these procedures except as covered elsewhere.
16. Treatment of autism.
17. Stomach stapling or other operations, medications or treatments to correct obesity.
18. Admissions to a Hospital on a non-emergency basis from 6:00 p.m. Friday through 12:01 p.m. Sunday are not covered unless the proposed treatment is actually rendered during this time. Otherwise all Hospital and related medical expenses incurred during that period for non-emergency admission will not be paid.
19. Prevention or promotion of conception or childbirth, including but not limited to: (1) artificial insemination; (2) treatment for infertility or impotency; (3) sterilization or reversal of sterilization; (4) elective termination of pregnancy; (5) IUD implantation or removal or in vitro fertilization.
20. Custodial care, preventive care, immunizations, nutritional supplements, routine physical exams except as specifically provided herein.
21. Personal items such as TV, admitting kits, cots for family members, guest meals an other items which are not medically necessary.
22. Services received outside of the United States, except for emergency treatment for onset of illness or injury while traveling for business, recreational purposes or vacation, for up to 90 days from date of departure.
23. Charges for services rendered by a Covered Person or anyone related by blood or marriage to the Covered Person.
24. Services or supplies not provided while the Policy is in force, provided that the termination of the Policy will not prejudice an existing claim.

25. Sex transformations or reversal and any complications resulting therefrom.
26. Charges which the Covered Person is not required to pay, which are covered by other insurance or which would not have been made if no insurance existed.
27. Charges covered by Medicare to the extent the person is, or could be, covered, or any government program or coverage required or provided by law.
28. Routine nursery care or circumcision for a Dependent child following birth, unless otherwise covered.

COORDINATION WITH MEDICARE

This Policy will coordinate with Medicare, as allowable under state law. An individual may continue to have coverage under this Policy once he or she is eligible for Medicare. However, We will pay benefits only for expenses which are not covered by Medicare.

CONVERSION

If the Insured and spouse, who are covered under this Policy, enter a decree of dissolution of marriage, the covered spouse and any already covered dependent children such spouse designates, shall be eligible for coverage under this Policy, as well as any other benefit option available under this Policy form type. Upon the death of the Insured these same options will be available to the covered surviving spouse and to any covered dependents and to a covered dependent child upon no longer meeting the definition of an Eligible Dependent. Written request for conversion and payment of the first monthly premium must be made within 31 days after termination of insurance under this Policy. Coverage shall commence as of the date insurance was terminated under this Policy.

HOW TO FILE CLAIMS

NOTICE OF CLAIM

Written notice of claim must be given to Us within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given to Us at Our Home or Our Administrative Office, or to any authorized agent of Ours, with information sufficient to identify the Covered Person, shall be deemed notice to Us.

CLAIM FORMS

We, upon receipt of a notice of claim, will send to the claimant a claim form for filing proof of loss, if necessary. If such forms are not furnished within 10 working days after giving notice, the claimant shall be deemed to have met the requirements of the Policy as to proof of loss upon submitting, within 90 days, written proof covering the nature and extent of the loss for which the claim is made.

PROOF OF LOSS

Written proof loss must be furnished to Us at Our Home Office or Our Administrative Office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not void or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the date of loss.

TIME OF PAYMENT OF CLAIMS

All benefits payable under this Policy will be payable immediately upon receipt of due written proof of loss. Should We fail to pay the benefits payable under this Policy, upon receipt of due written proof of loss, We shall have 15 working days thereafter within which to mail the Insured a letter or notice which states the reasons We may have for failing to pay the claim, either in whole or in part, and which also gives the Insured a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all the listed documents or other information needed to process the claim had been received, We will have 15

working days within which to process and either pay the claim or deny it, in whole or in part, giving the Insured the reasons We may have for denying such claim or any portion thereof. We shall pay interest to the Insured equal to 18% per annum on the proceeds or benefits due under the terms of the Policy for failure to comply with the requirements of timely payment.

PAYMENT OF CLAIMS

If any claim is payable to the estate of the claimant, or to a Covered Person who is a minor or otherwise not competent to give valid release, We may pay an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

COMPLAINT PROCEDURE

Informal Complaint Procedure

All people who work for Us share responsibility for assuring Your satisfaction with this plan. If You have a problem or concern, please ask for Our help. For help with a question or problem involving your health plan coverage (e.g., eligibility, enrollment, claims payment or denial of benefits) call Our office at 1-800-366-6663. Please give complete information so that the person with whom you speak can help You resolve your problem quickly.

Formal Complaint Procedure

If your problem is not resolved formally by discussing the matter with Our personnel, We have a formal complaint procedure that is described as follows:

You must give or send a written complaint to Our office within 30 days following the day of the occurrence which gave rise to the complaint. The complaint must state full details of the incident or matter, including date of occurrence, place and people involved. The address for Our customer service department is as follows: P.O. Box 7900, Lake Forest, Illinois 60045.

Each formal complaint will be reviewed by Our Review Committee. The Committee will respond in writing within 30 days following receipt of the complaint, unless You are notified in writing that additional time is required. In no event will action be delayed more than 90 days.

If You are not satisfied with the complaint resolution provided by the Review Committee, You may make a written appeal to the Panel Review Committee. You must give or send the written appeal to Trustmark Insurance Company (Mutual), P.O. Box 7900, Lake Forest, Illinois 60045 within 30 days after the Review Committee's response. You may add any additional facts to the written appeal not specified in the original complaint.

The Panel Review Committee will review the appeal and respond in writing within 30 days following receipt of the appeal, unless You are notified that additional time is required. In no event will action be delayed more than 60 days.

Complaints Submitted to the State of Georgia Office of Commissioner of Insurance

If we have not resolved your concern through the above procedure and you submit a complaint to the State of Georgia Office of Commissioner of Insurance, they will send a copy of your complaint to us. We will provide a written response to such complaint to you, with copies of such response to the appropriate department, within 10 working days of receipt from the State of Georgia Department of Insurance.

GENERAL AGREEMENT

We agree to issue this Policy to You because You paid the initial premium and met the eligibility requirements. We rely on the completed Application You made. The Application is attached and is a part of this Policy. Fraudulent or intentional omissions or material misrepresentations in the Application may cause a claim to be denied, or Your Policy to be rescinded. This Policy insures the

Persons named in the Application are approved by us. Covered Persons or coverage added or eliminated after the Policy effective date will be shown by amendment to this Policy.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT

This Policy, including the endorsements, Application, and any attached riders constitutes the entire contract of insurance.
Any statements made by a Covered Person will be deemed representations and not warranties. Only written statements signed by the Insured or the Covered Person will be used in defense of a claim. A copy of such written statement, if applicable, will be furnished to the Insured or the Covered Person or his/her beneficiary, if any, if a claim is denied based on such a statement.

AMENDMENT AND CHANGES

The policy may be amended by Us, but without prejudice to any loss incurred prior to the effective date of the amendment. Any changes to this Policy must be either required or approved by the Commissioner of Insurance in conformance with applicable state law or regulation. To be valid, any change or waiver attached to the Policy must be: (1) in writing; (2) approved by one of Our officers ; and (3) made a part of the Policy. No agent has the authority to change the Policy or waive any of its provisions, extend time for payment of premiums, waive any of Our rights or requirements, and no representations by an agent or any other person shall be binding on Us unless such representation is reduced to writing and signed by one of Our officers. Changes to the Policy may only be made on renewal. Modifications must be consistent with state law and uniformly affect all individuals with this Policy form.

CONFORMITY WITH STATE STATUTES

If any provision of this Policy, which, on its effective date is in conflict with the statutes of the state of Georgia, it is changed to conform to the minimum requirements of those statutes.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue on this Policy, no misstatements made by the Insured in the Application for this Policy shall be used to void the Policy or to deny benefits or claim for loss incurred as defined in the Policy, commencing after the expiration of such two-year period. This provision shall not limit the application of other provisions prescribing the effect of misstatement of age, occupation, or other insurance.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

We may obtain or release any information from or to any insurance company or any other organization without the consent of the Covered Person only to the extent permitted by state law. Any Covered Person claiming benefits under this plan shall supply information necessary to implement this provision.

RIGHT OF RECOVERY

In the event of any excess payments for benefits provided to any Covered Person under this Policy, We shall have the right to recover such payments. The right to recover may be from any person to whom such payments were made, any other insurers, service plans or any other organizations.
If You or Your covered dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this Policy, We may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical medical expenses under this Policy, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery may include compromise settlements. You or Your attorney must inform Us of any legal action or settlement agreement at least ten days prior to settlement or trial. We will then notify You of the amount it seeks to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

PREMIUMS

Premiums are due and payable in advance on a monthly basis unless another mode of payment is shown on the Schedule of Benefits. Premiums are payable to Us at Our Home Office or to Our authorized administrator. Premium amounts will change (1) on the Policy anniversary date based on the attained age of You and Your spouse, and (2) when the premium for all policies of this kind issued in Your state or class are changed, provided We have given You 60 days advance written notice prior to the Policy anniversary date.

GRACE PERIOD

If We do not give notice in writing that the Policy is to be terminated, the Insured is granted a grace period of 31 days for the payment of any premium falling due after the first premium. During the grace period, the Policy remains in force. Eligible claims incurred during the grace period will be payable upon receipt of the premium due. The Policy and all coverage thereunder automatically terminates on the last premium due date if the premium is not received during the grace period.

REINSTATEMENT

If a premium is not received within the time granted You for payment, a later acceptance of premium by us or an authorized agent, without a reinstatement Application, shall reinstate the Policy. If we require a reinstatement Application and give You a conditional receipt for the premium, the Policy will be reinstated as of the date of such conditional receipt, unless we notify You of our disapproval within 45 days of that date.

The reinstated Policy shall cover only loss resulting from any accidental injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten days after that date. In all other respects the Insured and We shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium.
Any premium accepted shall be applied to a period for which premium has not previously been paid, but not to any period more than 60 days prior to the reinstated date.

PHYSICAL EXAMINATION

We have the right to an independent medical exam of the covered Person whose injury or sickness is the basis of claim:

1. As often as reasonably necessary;
2. At Our expense; and
3. By a Physician of Our choice. We may request an autopsy where it is not forbidden by law.

LEGAL ACTION

No legal action may be brought to obtain benefits under the Policy:

1. for at least 60 days after written proof of loss has been furnished; or
2. after the expiration of three years after the time written proof of loss is required to have been furnished.

ASSIGNMENT

No assignment of any benefit or claim shall bind Us unless the same claim is filed in writing at Our Home Office prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Benefits under this Policy payable to the Insured shall be paid, with or without an assignment from the Insured, to public Hospitals or clinics for services or supplies provided to the Insured if a proper claim is submitted by the public Hospital or clinic. No benefits shall be payable to the public Hospital or clinic if such benefits have been paid to the Insured prior to receipt of the claim by Us. Payment of benefits to the public Hospital or clinic shall discharge Us from all liability to the Insured to the extent of the benefits so paid.

CLERICAL ERROR

A clerical error on Our part or the part of Our authorized administrator will not void insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable premium adjustment will be made. Complete proof must be supplied to Us documenting any clerical errors.

MISSTATEMENT OF FACTS

An equitable premium adjustment will be made in the event the age, sex or other premium affected facts of any Covered Person have been misstated. If the misstatement changes the amount of insurance, the Covered Person's insurance will be adjusted to the correct information. Any adjustment in premium will be based on the adjusted amount of insurance.